993

ARIZONA STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

ORIGINAL CERTIFICATE OF DEATH

State Index - - No. 160
County Registrar's No. 1686
Local Registrar's - No. 119216

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PLACE OF DEATH

1. County Maricopa
District Phoenix
Town or City Phoenix
No. Arizona State Hospital St., K. Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2. FULL NAME Charles Drew

(a) Residence. No. State Hospital St., K. Ward.
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 1 yrs. 6 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4 COLOR or RACE	5 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
male	white	married

5a. If married, widowed, or divorced
HUSBAND of ~~(or) WIFE of~~ Mrs. C. Drew

6. DATE OF BIRTH (month, day and year) 1875

7. AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	47			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Amer.
(State or country)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town)
(State or country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town)
(State or country)

14. Informant Hospital Records, Phy.
(Address)

15. Filed 12-20 19 I. L. GARRISON, M. D.
Registrar

V. S. No. 1

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (month, day, and year) 12/19/22 19

17. I HEREBY CERTIFY, That I attended deceased from 6/2/22, 19 to 12/4, 19 22,
that I last saw h[illegible] alive on 12/3/22, 19
and that death occurred, on the date stated above, at 6:2 A/M. m.
The CAUSE OF DEATH* was as follows:

Paresis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Wassermann

(Signed) F. H. Schwarz, M. D.
19 (Address)

* State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asylum Cem.	12/20/22 1922
20. UNDERTAKER	ADDRESS